

# Final Report of the Quality Working Group

**April 23, 2001**

Virginia Latham, The President of the Massachusetts Medical Society provided the perspective we bring to this report when she said the goal of the health care system is to “cure the sick, alleviate suffering and comfort the dying.” She reminds us that the focus of the entire system must be on the patient. To achieve this, our Working Group believes health care providers and payers must continually strive to improve patient centered quality and reduce error. No matter how good a job we are doing now, we can do better. No matter how few errors there are now, there could be less.

In our preliminary Report we provided:

- A patient centered definition of quality
- Conclusions that the quality of care could be measured and reported more effectively than it is now. We concluded that consumers or purchasers do not yet use plan level quality reporting, especially since there is so much overlap in provider networks in Massachusetts. We urged that efforts be made to collect and analyze quality and error data at the provider level and in ambulatory settings to improve our understanding of both system and individual performance issues.
- Concerns that the financial and staffing difficulties of the nursing home industry presented an immediate threat to quality and safety for our most vulnerable population. Developments since our report only reinforce these concerns. The Working Group continues to believe that urgent State action is needed to address staffing and patient safety monitoring in nursing home and home care

settings.

Since we last reported the Working Group has:

- Met with representatives of major provider, professional and advocacy groups to hear their recommendations and to learn more about their current approaches to measuring quality and reducing error.
- Received oral and written recommendations from many of the voluntary quality improvement groups now at work in the Commonwealth.
- Held discussions with individual providers from different disciplines and communities.
- And reviewed the findings of the Institute of Medicine Report on the quality of care in the United States and other relevant literature.

We are grateful to all of those who took time to respond to our questionnaire and to meet with us. Their experience and ideas helped shape our thinking. This Report reflects the strong consensus of the members of the Working Group. We summarize our conclusions as findings that provide background for the specific policy options we recommend.

## **FINDINGS**

**Finding One: The Working Group concludes that medical errors and less than best practice quality contribute to the financial problems facing the State's**

**health care system, in addition to unneeded suffering.** Inadequate systems that lead to errors and patient concerns about quality add to the total cost of care. For example, medication errors that result in a longer length of stay or other complications add to total cost. Conversely, we do not believe that financial relief measures for distressed institutions, by themselves, will solve the financial problems facing many providers. If consumers are passing by some hospitals or medical groups because they believe other providers will deliver higher quality care, short term subsidies may not reverse the trend. On the other hand, Commonwealth supported investments that measurably improve patient focused quality coupled with objective reporting on key patient quality indicators may help many consumers and purchasers make more effective choices. Therefore, the Working Group believes that a continuous effort to reduce errors and improve quality—from the patients’ perspective-- will help solve part of the financial stress in the system.

Finding Two: **Providing the highest quality of care to each patient and reducing the possibility of error is not always the primary focus today.** The Working Group was presented with many examples in which providers’ and institutions’ attention is diverted from the individual patient’s needs by other pressing institutional, regulatory or financial issues. For example, a nurse anesthetist described circumstances in which she was required to leave a complicated case that needed her level of skill to cover another operating room with a less serious case in order for the hospital and physician group to bill for the second case. Physicians told us that paperwork relating to regulatory and financial considerations now take several hours a day, some of which should be spent

with patients. We were provided with numerous examples of how current financial incentives work against focusing on patient quality and safety, especially in treating mental illness and providing nursing home and home care. Therefore the Working Group believes the regulatory and financial framework in the Commonwealth should be revised to put explicit emphasis on patient safety and quality at the core of all decisions.

Finding Three: **There are exemplary voluntary quality improvement and medical error reduction efforts underway in the Commonwealth, for example the Mass Health Quality Partnership and the Coalition for the Prevention of Medical Errors. Nevertheless, the Working Group found that culture; finance and practice significantly inhibit the rate of adoption of evidence based care guidelines, improvements in patient oriented information technologies, and a focus on chronic conditions.** Some new technologies that significantly improve patient quality, such as minimally invasive surgical techniques, have spread quickly. Others such as computerized order entry and pharmacy systems that could reduce the waste and suffering caused by errors have lagged in many places.

The Working Group found a particular lag between the current focus on error reduction and quality reporting in the acute inpatient setting and the reality that most care is now provided on an ambulatory basis to people with chronic conditions where there is a dearth of regular quality analysis and reporting. The Working Group heard many examples of how the acute care orientation of financial and care management arrangements fail to recognize the needs of patients with chronic conditions, especially mental illness. The Working Group believes that the acute care focus of most current

efforts is itself a barrier to improving the quality of ambulatory and chronic care.

Finding Four: **The Working Group finds that significant improvement is needed in data collection and analysis especially at the individual institution and provider level.** While the Working Group believes that more information can and should be made public, it recognizes that getting and using quality related information in a continuous improvement process might be more important than public reporting in some instances. This is especially true when issues of quality and error are caused more by the system of care than by the actions of individuals involved in a particular incident. The Working Group believes that it may be appropriate for quality and error information to remain confidential when disclosure would inhibit use of the information to learn and make improvements. At the same time, the Working Group believes that payers, patients and regulators need to have assurance that such information is really being used in a continuous quality improvement process that leads to measurable results.

Finding Five: **A continuous effort to improve patient centered quality and reduce error will be a cooperative effort between public and private stakeholders. The Working Group finds that The State government has five distinct tools available to it as an active leader and participant in efforts to improve quality and reduce errors.** They are:

- Purchasing power. The State is the largest purchaser of care through its State Employee health program and through Medicaid. It should use this leverage to help create and monitor patient centered quality improvement. For example both the

Group Insurance Commission and Medicaid have become actively involved in quality improvement efforts.

- **Licensing.** The State decides what institutions and individuals may legally provide health care in the Commonwealth and the scope of services they may provide. Licensing standards and associated public reporting such as the Department of Public Health's Nursing Home Inspection Reports can have an impact on the quality of care. The Working Group believes that State Licensing Board procedures should build on the experience of the Patient Care Assessment process that focuses on improving systems to prevent errors as well as reviewing individual responsibility for error.

- **Regulation.** The State has broad regulatory powers that can be used to focus increasing attention on reducing error and improving quality. Using these broad powers, the State can play a constructive convening role for key stakeholders.

- **Financing,** through tax preferences, subsidies, guarantees or other means. The State can influence the amounts and uses of capital and operating funds for the health system. For example, State tax-exempt financing authority has been a central tool in modernizing and expanding the health care system.

- **Consumer education.** The State can organize and disseminate information about quality in the health care system. For example, both the Group Insurance Commission and the Office of Consumer Affairs publish quality related information aimed at lay consumers.

## **POLICY GOALS**

Policy Goal One: **The State should adopt the concept of “patient centered quality” as the overriding principle of all State regulatory and financial policies.** All new and existing policies should be reviewed with the question: Does this policy move the health system closer to being focused on patient centered quality and how will we measure and report the result? Regulations that do not meet this test should be revised or repealed.

The State should use its purchasing power to develop quality improvement efforts. State programs should consider providing financial incentives to providers that demonstrate and measurably deliver patient centered quality improvements. Conversely, the State should not contract with providers that cannot, over time, achieve appropriate levels of quality and error reduction. There are some examples of where the State is already doing this. The Group Insurance Commission has committed to following purchaser standards developed by the Leapfrog. The Leapfrog group has developed a multi-year effort to reduce hospital errors by pushing for computerized order entry and pharmacy systems, improving outcomes by concentrating patients in facilities that do sufficient volume in particular procedures for which volume is a relevant indicator of quality; and by insisting that specially trained intensivists staff hospital ICU's.

In its roles as licenser and regulator, the State should develop patient centered quality criteria for getting and keeping facility and practice licenses.

In its role as educator, perhaps through a new Center for Patient Centered Quality, Safety and Error Reduction, the State should work with Health Plans and providers to develop and disseminate provider level profiles of patient centered quality of care. The



Working Group recognizes that provider level reporting must accurately reflect the relative roles of institutional systems and individual actions in producing the outcomes being measured. The commitment to develop and disseminate this kind of reporting should be long enough for the reports to gain broad consumer and professional credibility and use.

The State should participate and help finance partnership efforts to review and report error and quality issues at the provider level, provided that the reports are made public whenever appropriate and that all providers participate in the process. The Working Group was impressed by the careful process being followed by the Mass Health Quality Partnership and endorses its approach as a model. If continued reliance on voluntary participation by institutions leads to full participation, State action may not be necessary.

Policy Goal Two: **An increasing proportion of medical care in Massachusetts should make use of evidence based best practice guidelines.** Providers and their organizations should participate in the consensus development process that leads to recommending particular guidelines and in implementing systems that ensure their adoption. Continued resistance to using consensus guidelines should be identified and addressed by providers, regulators and payers. Public and private payers should specify progress toward use of evidence based guidelines in their reimbursement policies. Over time, use of best practice guidelines, when available, should replace “accepted community practice” as the standard of care in legal and regulatory matters.

In conjunction with efforts growing from the IOM report, the Commonwealth

should develop a method of tracking and publicly reporting on the most common medical conditions of patients. These reports should track changes in evidence-based care for these conditions and population level changes in the health status of people with these common conditions.

Policy Goal Three: **Financial incentives should be changed so they encourage patient centered quality.** As the Institute of Medicine Report states:

Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build stronger incentives for quality enhancement.”

The State as payer can consider paying plans or providers bonuses or higher rates for measurable improvements in quality and error reduction.

State financial support such as low cost bonds or grants for health care providers should be targeted for investments that yield measurable improvements in patient centered quality. For example, State low or no interest bonds can be directed toward addressing patient centered quality problems such as computerized order and pharmacy entry systems or technology improvements in nursing homes that improve patient safety monitoring.

Policy Goal Four: **Quality and error reporting provided by public and private**

**collaboratives should be significantly expanded, especially at the provider level.** In its role as a regulator and convener, the State should continue to require quality defect reporting and should develop new ways to measure and monitor quality and errors in outpatient and office settings. The State should facilitate collaboration among stakeholders to limit the overall reporting burden on providers while focusing attention on the most important and high yield areas of improvement. If protection from public reporting is to be granted, providers and quality improvement groups should be required to demonstrate that they use continuous quality improvement and error reduction programs to learn from protected error reporting.

The Working Group respects the current processes now in place in the Commonwealth and the careful ways in which information is reviewed and improvement programs developed both in and outside the public spotlight. If all providers do not make steady progress toward full participation, the State should consider making participation in a quality reporting system mandatory for all settings, ambulatory as well as hospitals, in a manner consistent with the recommendations in the Institute of Medicine Report.